STANDARD 2

The Indian health Diabetes Self-Management Education entity will determine its target population, assess educational needs and identify the resources necessary to meet the self-management educational needs of the target populations.

Applicant Notes:

LEVEL 1

developmental

(checklists on pages 67 and 79)

EDUCATION PROGRAM

Tasks that need to be accomplished in order to develop an education program are identified and outlined.

ASSESSMENT

The program describes its target population (newly diagnosed, gestational, elders, youth, etc.), documents assessment activities, describes educational needs of target population(s), and identifies program goals and objectives.

RESOURCE REQUIREMENTS

The program identifies the space, staffing, budget, instructional materials, staff education and other resources needed to develop and maintain the diabetes education program. There is evidence of an assessment process to identify education resources and interventions known to be successful for American Indian/Alaska Native communities.

LEVEL 2

educational

(checklists on pages 67 and 79)

ANNUAL GOALS AND OBJECTIVES

There is evidence of annual program goals and objectives which are realistic, measurable and consistent with the needs of the population served. Team meeting agendas/minutes reflect tracking and progress towards annual goals/objectives. Resources are provided to meet identified goals and objectives.

TARGET POPULATION

There is evidence that Diabetes Self-Management Education services meet the needs of the target population. Evidence can include team minutes, population assessments, community surveys, marketing brochures and other related materials.

RESOURCE REQUIREMENTS

There is evidence of ongoing resource assessment as programs expand to meet community needs.

ACCESS TO CARE

There is evidence that the Indian health diabetes education entity defines how a consumer gains access to care. Evidence can include documentation in team minutes and/or program manual. Documentation should include a short description of community access challenges/barriers and methods or strategies used to improve access.

STANDARD 2

The Indian health Diabetes Self-Management Education entity will determine its target population, assess educational needs and identify the resources necessary to meet the self-management educational needs of the target populations.

Applicant Notes:

Diabetes prevention and control services are considered at three levels:

- Primary Level: The maintenance of health by removal of precipitating causes and determinants or departures from good health
- Secondary Level: The early detection and management of disease before it has time to progress and cause irreversible damage
- Tertiary Level: Preventing deterioration and complications from occurring when disease or disability is already established

LEVEL 3

integrated

(checklist on page 81)

ANNUAL GOALS AND OBJECTIVES

Community assessment information is expanded and utilized for annual planning. Diabetes team develops goals and objectives based on assessment information. Methods shall include use of information (community profiles, surveys, diabetes audit data, complications, etc.) obtained from various assessment activities (tribal administration services, clinical or other public health approaches). There is evidence of community-based and clinical diabetes prevention programs.

TARGET POPULATION

There is evidence that Diabetes Self-Management Education services meet the needs of the target population. Evidence can include team minutes, population assessments, registry analysis, etc.

RESOURCE REQUIREMENTS

There is evidence of ongoing resource assessment as the program expands to meet community needs.

ACCESS TO CARE

The program defines how a community member gains access to the education and clinical services (referral, self-referral, etc.). Community access issues for both educational programs and clinical services are further defined and documented. Marketing strategies are developed to help increase access to educational and clinical services.

COMMUNITY PREVENTION

There is evidence of community-based prevention activities to promote healthy lifestyles (examples: school health, elder programs, community group education, community healthy cooking classes, etc.).

CLINICAL CARE

There is a system in place for maintaining continuity of care. This includes a mechanism to identify cases lost to medical and educational follow-up. The utilization of follow-up services is tracked.